STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155200	A. BUILDING	01	04/30/2012
		100200	B. WING	ADDRESS, CITY, STATE, ZIP CODE	04/00/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹		UNIVERSITY BLVD	
UNIVERS	SITY NURSING CE	NTER		ID, IN 46989	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
ROOOU					
	A Life Safety C	ode Recertification	K0000		
	I -	isure Survey was			
		the Indiana State			
	· ·				
	Department of				
	accordance wit	:h 42 CFR 483.70(a).			
	Survey Date: 0	04/30/12			
	Facility Numbe	r: 000107			
	Provider Numb				
	AIM Number:				
	All Number.	100290330			
	 Survevor: Amv	Kelley, Life Safety			
	Code Specialist				
	At this Life Safe	ety Code survey,			
		sing Center was			
	found not in co				
		for Participation in			
	Medicare/Medi	·			
	· ·	O(a), Life Safety			
	·	the 2000 edition of			
	the National Fi				
		FPA) 101, Life Safety			
		apter 19, Existing			
		ccupancies and 410			
	IAC 16.2.				
	This one story	•			
	determined to	be of Type V (000)			
	construction a	nd was fully			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000107

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	(X3) DATE COMPL		
		155200	A. BUII B. WIN	LDING G		04/30/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY NURSING CE	NTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	alarm system we detection in the areas open to t	e corridors and he corridors. There letectors in the at this time. The apacity of 75 and f 55 at the time of Robert Booher, Life Safety dical Surveyor on 05/04/12.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 2 of 29

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	A. BUI	LDING	ONSTRUCTION 01	(X3) DATE (COMPL 04/30 /	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A 1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0018 SS=E	Doors protecting than required enexits, or hazardo doors, such as the solid-bonded corresisting fire for a sprinklered build resist the passage impediment to the Doors are provide keeping the door meeting 19.3.6.3 Roller latches are regulations in all Based on obserview, the fensure there we to the closing or room doors proopenings on the deficient practice residents in the Findings include Based on observations and the service of the control of the c	acility failed to ere no impediments of 1 of 10 resident otecting corridor e Cottage. This ce could affect 16 e Cottage. The cottage of the	K00	018	K 018: Resident Room Doors Closing What corrective action(s) will the accomplished for those reside found to have been affected bethe deficient practice: The beds in Room 207 was rearranged to allow the door to close properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	e e	05/30/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 3 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	01	(X3) DATE SURVEY COMPLETED		
		155200	A. BUILDING B. WING	- ·	04/30/2012	
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD ID, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-19(b)			All residents have the potential to be affected by the deficient practice. Memory Care Facilitator/Designee will mon all residents' rooms to ensure doors close properly. Any rooms found to have corridor door that will not close properly will be corrected immediately. Memory Care	itor e the re a	
				Facilitator/Designee will document this monitoring on Auguste's Cottage Room Room What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not re-	ster. to ges ne	
				Memory Care Facilitator/Designee will mon all residents' rooms to ensure doors close properly. Any rooms found to have corridor door that will not close properly will be corrected immediately All rooms will be monito on a daily basis for 4 weeks, weekly for 3 months, then monthly thereafter for a mining.	e the ve a se ve the ve	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 4 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

155200 B. WING 04/3	COMPLETED 04/30/2012					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
UNIVERSITY NURSING CENTER 1564 S UNIVERSITY BLVD UPLAND, IN 46989						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE					
of six months. Memory Care Facilitator/Designee will document this monitoring on the Auguste's Cottage Room Roster. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: Memory Care Facilitator/Designee will monitor all residents' rooms to ensure the doors close properly. All rooms will be monitored on a daily basis for 4 weeks, then weekly for 3 months, then monthly thereafter for a minimum of six months. Memory Care Facilitator/Designee will document this monitoring on the Auguste's Cottage Room Roster. The Auguste's Cottage Room Roster Monitoring tool will be reviewed at the monthly Coll for a minimum of six months and the plan will be adjusted as necessary.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 5 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:								
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	SITY NURSING CE		1564 S UNIVERSITY BLVD UPLAND, IN 46989					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				By what date the systemic changes will be completed:				
				Systemic changes will be completed by 05/30/12.	•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet Page 6 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155200	A. BUIL		01	04/30/	
		133200	B. WING	_	DDDDGG GYRY GRADE GYD GODE	0-7307	2012
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY NURSING CE	NTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=E	One hour fire rat fire-rated doors) fire extinguishing 8.4.1 and/or 19.3 areas. When the extinguishing system areas are separas smoke resisting are self-closing a protective plates		K00	29			05/30/2012
	interview, the fensure the cornhazardous area heater rooms a combustible stover 50 square provided with a device. This decould affect an 300 hall clean staff in the service Maintenance State of 12 from p.m., the corries service hall was door to the 300 hazardous and the service hall was door to the 300 hazardous and the service hall was door to the 300 hazardous area hazardous a	racility failed to ridors doors 2 of 2 as such as water and rooms with orage measuring feet in size were a self closing eficient practice y resident near the utility room and any vice hall.			What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: The door to the service he water heater room and the door to the 300 Hall clean utility roo have had self closing devices installed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	nts / all or m	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet Page 7 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED 04/30/2012	
		155200	B. WING			04/30/	2012
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY NURSING CE	NTER			UNIVERSITY BLVD D, IN 46989		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	feet in size wit storage, such a lacked a self cl	h combustible as bedding, each osing device. This by the Maintenance		TAG	All residents have the potential to be affected by the deficient practice. The doors to the service water heater room and to the 3 Hall clean utility room have has self closing devices installed. All other corridor doors in the facility for hazardous areas such as mechanical and storal rooms have been checked for closures. Those doors found to be need of self closures have had them installed.	300 d s s ge self	DATE
					What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recommend. The Maintenance Director will monitor all rooms in the facility on a monthly basis to ensure the door does not requal a self closure.	es e ur: or	
					 The Maintenance Director will be responsible to ensure a doors in the facility that need so closures have them installed The Maintenance Director will ensure that any new doors installed in hazardous areas or 	all self or	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 8 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED				
		155200	B. WIN	G		04/30/	2012
NAME OF P	PROVIDER OR SUPPLIE	R	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
	NT (NU IDOINIO OF	-NTED			UNIVERSITY BLVD		
UNIVERSITY NURSING CENTER				UPLAN	D, IN 46989		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OF	R ESC IDENTIF TING INFORMATION)	+	IAG	storage rooms will have self		DATE
					closures.		
					How the corrective action(s) w	/ill	
					be monitored to ensure the		
					deficient practice will not recu	r;	
					i.e. what quality assurance program will be put into place:		
					program will be put into place.		
					The Maintenance Discret	_	
					The Maintenance Director will monitor all rooms in the	or	
					facility on a monthly basis to		
					ensure the door does not requ	ıire	
					a self closure.		
					These inspections will be	,	
					documented on Maintenance	ĺ	
					Director's Preventative		
					Maintenance Monthly Checklis	st.	
					The Executive Director w	/ill	
					audit the Preventative	,	
					Maintenance Manual at the er	nd	
					of the month to ensure all wee	-	
					and monthly audits have been	1	
					completed. The Executive Director will sign the pages of	the	
					appropriate Preventative		
					Maintenance Checklists as		
					documentation that the manua	al	
					has been reviewed.		
					· Any discrepancies in the		
					plan will be reviewed at the		
					monthly CQI meeting for a		
					minimum of six months. The will be adjusted as necessary.		
					will be aujusted as necessary.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 9 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE S COMPL 04/30/	ETED		
UNIVERS	PROVIDER OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE		
				By what date the systemic changes will be completed				
				· Systemic changes will completed by 05/30/12.	ill be			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 10 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 0		01	COMPL	ETED	
		155200	B. WIN			04/30/	2012	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER				UNIVERSITY BLVD			
UNIVERS	SITY NURSING CE				D, IN 46989			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K0038 SS=E	Exit access is arr	ODE STANDARD ranged so that exits are e at all times in accordance 19.2.1						
	Based on obser	vation and	K00)38			05/30/2012	
	interview, the fa	acility failed to			K 038 Exit Access			
	ensure 6 of 8 e	•						
	accessible. Hea							
	occupancies are				What corrective action(s) will b	oe		
	=				accomplished for those residents			
	delayed-egress				found to have been affected by the deficient practice:	y		
	conditions of L							
		iet. LSC 7.2.1.6(d)						
	requires on the	door adjacent to						
	the release dev	ice there shall be a			All exit doors in the facility	V .		
	readily visible,	durable sign in			except those located in the	,,		
	=	than 1 inch high			Auguste's Cottage Alzheimer's	3		
	and not less th	-			Unit, have the appropriate			
	width on a cont	•			signage posted regarding push	-		
		-			the door for 15 seconds to ope	₽n.		
	_	at reads as follows:						
	"PUSH UNTIL AL							
	DOOR CAN BE				How other residents having the	е		
	SECONDS". Thi	s deficient practice			potential to be affected by the			
	could affect any	y number of			same deficient practice will be			
	occupants.				identified and what corrective			
					action(s) will be taken:	ļ		
	Findings includ	e:						
	. J				· All residents have the			
	Rased on obser	vations with the			potential to be affected by the			
					deficient practice.			
	Maintenance Su	•			All exit doors in the facility	V		
	· · ·	1:15 p.m. to 2:30			except those located in the	y ,		
	=	loors on the 100			Auguste's Cottage Alzheimer's	3		
	hall, in the 300	lounge, on the			Unit, have the appropriate			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet Page 11 of 29

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	A. BUI	LDING	ONSTRUCTION 01	(X3) DATE SU COMPLET 04/30/2	ГЕО
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	in the vending at the main ent				signage posted regarding pust the door for 15 seconds to ope		
	equipped with electromagnetic locks that released after pushing the door for 15 seconds but lacked signage regarding pushing the door to open. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1–15(b)			What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not rec	es e		
				The Maintenance Director/Designee will monitor exit doors, except those in Auguste's Cottage Alzheimer's Unit, to ensure the posted signare in place.	s		
					Any doors found to be without the appropriate signag will have the signs replaced immediately.	ie	
					How the corrective action(s) we be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:	··· ,	
					The Maintenance Director/Designee will monitor exit doors, except those in Auguste's Cottage Alzheimer's Unit, to ensure the posted signare in place. This exit door monitoring	s 1S	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 12 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155200	A. BUILDING B. WING	01	COMPLETED 04/30/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	_
UNIVERS	SITY NURSING CE	NTER		UNIVERSITY BLVD D, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				be documented on the CQI Ex Sign Monitoring Tool.	cit
				This monitoring will be do on a weekly basis for 4 weeks then monthly thereafter for a minimum of six months.	
				The CQI Exit Sign Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of months.	
				By what date the systemic changes will be completed:	
				· Systemic changes will be completed by 05/30/12.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 13 of 29

STATEMEN	IT OF DEFICIENCIES	ENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVE				URVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155200	B. WIN			04/30/2	2012
NAME OF T				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER			1564 S	UNIVERSITY BLVD		
UNIVERS	SITY NURSING CEI			UPLAN	ID, IN 46989		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0044 SS=E	NFPA 101	ODE STANDARD					
33-E		if used, are in accordance					
	with 7.2.4. 19.						
	Based on obser	vation and	K00)44	K 044 Horizontal Exits What	at	05/30/2012
	interview, the f				corrective action(s) will be		
					accomplished for those reside		
		fire door sets was			found to have been affected by	, ,	
	_	tomatically close			the deficient practice: • The fire doors in the 100 Hall have		
		19.2.2.5 requires			been repaired and now close		
	horizontal exits				properly. How other reside	nts	
	accordance wit	h 7.2.4 and			having the potential to be affect		
	7.2.4.3.8 requi	res fire doors to be			by the same deficient practice		
	self closing or a	automatic closing			be identified and what correction	-	
	in accordance v	with 7.2.1.8. In			action(s) will be taken: · All residents have the potential to		
	addition NFPA	80, Standard for			affected by the deficient practic		
		Fire Windows at			· The fire doors in the 100 Ha		
	2-1.4.1 require	es all closing			have been repaired and now		
	<u> </u>	nall be adjusted to			close properly. What measures will be put into place	or	
		esistance of the			what systemic changes will be		
	latch mechanis				made to ensure that the deficie		
		eved on each door			practice does not recur: · T		
	_				Maintenance Director/Designe	е	
	-	s deficient practice			will monitor all fire doors on a weekly basis to ensure the doo	ore	
	could affect an	•			close properly. How the	015	
	residents on th	e 100 hall.			corrective action(s) will be		
					monitored to ensure the deficie	ent	
	Findings includ	e:			practice will not recur; i.e. wha		
					quality assurance program will	be	
	Based on obser	vation with the			put into place: The Maintenance Director/Designe	_	
	Maintenance Su	pervisor on			will monitor all fire doors on a	~	
	04/30/12 at 1:	05 p.m., a raised			weekly basis to ensure the doo	ors	
	area of the con	crete floor			close properly. The monitor	ing	
	prevented the e	east side fire door			of the fire doors will be documented on the Preventati	vo	
	on the 100 hall				Maintenance Weekly Checklis		
		latching into the			The Executive		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet Page 14 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 04/30/2012
	PROVIDER OR SUPPLIER SITY NURSING CENTER	1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD ID, IN 46989	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	door frame. There was a fourteen inch gap between the door and the door frame. Based on an interview with the Maintenance Supervisor at the time of observation, these doors were confirmed to be fire doors. 3.1–19(b)		Director/Designee will monito Preventative Maintenance Checklist on a weekly basis for weeks, then monthly thereafter for a minimum of six months. This monitoring will be documented on the CQI Preventative Maintenance Weekly/Monthly Checklist Monitoring Tool. • The CQI Preventative Maintenance Weekly/Monthly Monitoring Twill be reviewed for compliant the monthly CQI meeting for a minimum of 6 months. By what date the systemic change will be completed: • System changes will be completed by 05/30/12.	or 4 er ool ce at a ges mic

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 15 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	01	COMPL	ETED
		155200	B. WIN			04/30/	2012
NAME OF B	DOLUBED OF GUIDNIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	ROVIDER OR SUPPLIER			1564 S	UNIVERSITY BLVD		
UNIVERS	SITY NURSING CEI	NTER		UPLAN	D, IN 46989		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
K0048 SS=C	NFPA 101	ODE STANDARD					
33-0		n plan for the protection of all					
		their evacuation in the event					
	of an emergency	v. 19.7.1.1					
	Based on recor	d review and	K00)48	K 048 Fire Extinguishers		05/30/2012
	interview, the f	acility failed to			I NOTO THE EXIMINGUISHERS		
	provide a writte	en plan that					
	included the us	se of all fire					
	extinguishers i	n 1 of 1 written fire			What corrective action(s) will be		
	plans. LSC 19.	7.2.2 requires a			accomplished for those reside found to have been affected by		
	written health o	care occupancy fire			the deficient practice:	′	
	safety plan that	t shall provide for			·		
	the following:	•					
	(1) Use of alarn	ns			The facility's Emergency		
	, ,	on of alarm to the			 The facility's Emergency Fire Plan has been updated to 		
	fire department				include the types of fire		
	(3) Response to				extinguishers throughout the		
	(4) Isolation of				facility; including the kitchen K		
	` '	of immediate area			class in relationship with the use of the kitchen hood extinguishing		
	(6) Evacuation (system.	''9	
	` '	or smoke					
	compartment	of floors and					
	(7) Preparation				How other residents having the	-	
	building for eva				potential to be affected by the	,	
	(8) Extinguishm				same deficient practice will be		
	•	oractice could affect			identified and what corrective		
	all occupants.				action(s) will be taken:		
	Findings includ	le:					
					· All residents have the		
	Based on a reco	ord review with the			potential to be affected by the		
	Maintenance Su	pervisor on			deficient practice.		
		2:55 p.m., the "Fire			The facility's Emergency		
		d not address the			 The facility's Emergency Fire Plan has been updated to 		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 16 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		155200	B. WIN	G		04/30/2012	
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIEF			1564 S	UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	types of fire ex	tinguishers			include the types of fire extinguishers throughout the		
	throughout the	facility including			facility; including the kitchen K		
	the kitchen K c	lass fire			class in relationship with the us		
	extinguisher in	relationship with					
	the use of the	kitchen hood			system.		
	extinguishing s	system. Based on					
		th the Maintenance					
		he time of record		of the kitchen hood extinguishing			
	I	er documentation			1 .		
	was available f						
	was available is	or review.			deficient practice does not rec	ur:	
	3.1-19(b)						
	3.1-19(0)						
					The facility's CQI Commit		
					was reviewed and updated the		
					American Senior Communities Disaster Manual at their meeti		
					on 05.17.12.	19	
					• The American Senior		
					Communities Disaster Manual		
					includes the required informati on the types and uses for the f		
					extinguishers located through		
					the facility.		
					How the corrective action(s) w	ill	
					be monitored to ensure the		
					deficient practice will not recur	,	
					i.e. what quality assurance		
					program will be put into place:		
					· The Maintenance		
					Director/Designee will be		
					responsible to monitor all fire		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 17 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155200	A. BUILDING B. WING	01	COMPLETED 04/30/2012
	ROVIDER OR SUPPLIER		1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD ID, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				extinguishers throughout the facility to ensure the correct fir extinguishers are in use in the proper areas of the facility.	
				The Maintenance Director/Designee will be responsible to monitor all fire extinguishers throughout the facility to ensure they are inspected by our service provi as required.	der
				The Maintenance Director/Designee will docume this monitoring on the Preventative Maintenance Weekly/Monthly Checklist on a monthly basis for a minimum 12 months.	a
				review the Preventative Maintenance Checklist on a monthly basis to ensure all required inspections have occurred. The Executive Dire will document these reviews b signing the Preventative Maintenance Checklists.	ctor
				The CQI Preventative Maintenance Weekly/Monthly Monitoring Tool will be review for compliance at the monthly CQI meeting for a minimum of months.	
				By what date the systemic changes will be completed:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 18 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155200	A. BUILDING B. WING	01	COMPLETED 04/30/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD	
	SITY NURSING CE			D, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	· Systemic changes will be completed by 05/30/12.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet Page 19 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPLETED	
		155200	B. WIN			04/30/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			ID, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0062 SS=F	Required automated continuously mail condition and are	ODE STANDARD atic sprinkler systems are intained in reliable operating e inspected and tested 9.7.6, 4.6.12, NFPA 13,					
	Based on recordinterview, the fensure 1 of 1 a	acility failed to utomatic dry	K00	62	K 062 Automatic Sprinkler Systems		05/30/2012
	inspected every required by NF Standards for t Testing and Ma Water-Based Fi Systems 10-2.2	r five years as PA 25, the he Inspection, hintenance of			What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice:	nts	
	practice affects Findings includ	all occupants.			The dry sprinkler piping system was inspected on 06/29/07. A reinspection has been scheduled for June.		
	Maintenance Sureview of the Prinspection on Op.m., there was to show an interinspection for the piping system	.04/30/12 at 12:48 s no documentation ernal pipe the dry sprinkler			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the		
	=				potential to be affected by the deficient practice. The dry sprinkler piping system was inspected on 06/29/07.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet Page 20 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 04/30/2012
	ROVIDER OR SUPPLIER		STREET A 1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD ID, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE COMPLETION
	time of record sprinkler piping attic and the el 3.1-19(b)	g system is in the		What measures will be put place or what systemic cha will be made to ensure that deficient practice does not	nges the
				The Maintenance Director/Designee will be responsible to ensure all inspections are completed required.	as
				All required inspection be kept by the Maintenance Director in an inspections be	e
				How the corrective action(s be monitored to ensure the deficient practice will not re i.e. what quality assurance program will be put into pla	ocur;
				The Maintenance Director/Designee will be responsible to ensure all inspections are completed required.	
				All required inspection be kept by the Maintenance Director in an Inspections E The Executive Director/Designee will mon	e Binder.
				Director/Designee will mon	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 21 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155200	A. BUILDING B. WING	01	COMPLETED 04/30/2012
	ROVIDER OR SUPPLIER		1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Inspections Binder on a month basis to ensure the required inspections have been completed.	nly
				The Inspection Binder wi monitored for a minimum of 12 months and documented on the CQI Inspections Monitoring To located in front of the Inspection Binder	2 ne pol
				The CQI Inspections Monitoring Tool will be review for compliance at the monthly CQI meeting for a minimum of months.	
				By what date the systemic changes will be completed:	
				· Systemic changes will be completed by 05/30/12.	3

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 22 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	01	COMPLETED	
		155200	B. WIN			04/30/	2012
NAME OF B	DOLUBED OF GUIDNIED		_	STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1564 S	UNIVERSITY BLVD		
UNIVERS	SITY NURSING CEI	NTER		UPLAN	ID, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0069 SS=E	NFPA 101	ODE STANDARD					
33-E		are protected in accordance					
	with 9.2.3. 19.						
	1. Based on re	cord review and	K00)69			05/30/2012
	interview, the f	acility failed to			K 069 Dietary Hood Inspection	ns	
	ensure 1 of 1 h	ood extinguishing					
	systems in the						
	=	serviced every six			What corrective action(s) will be		
	=	96, the Standard			accomplished for those reside		
		Control and Fire			found to have been affected by the deficient practice:	у	
		ommercial Cooking			the denoient produce.		
		ction 8–2 requires					
	_ =	nd servicing of the			The distant head		
		ng system at least			The dietary hood extinguishing system was		
	_	hs. This deficient			inspected on 05/04/12.		
	=	affect any resident					
	·=	oom and kitchen					
	_	nt of an emergency.			How other residents having the	2	
	stair iii tile eve	int of all efficiency.			potential to be affected by the	-	
	Findings includ	lo.			same deficient practice will be		
	Findings includ	e.			identified and what corrective		
	D	ما من المار الم			action(s) will be taken:		
	Based on record						
	Maintenance Su	-					
		2:41 p.m., the last			· All residents have the		
	kitchen hood ir	•			potential to be affected by the		
	completed by E				deficient practice.		
	· ·	07/08/11. Based			· The dietary hood		
	on an interview				extinguishing system was		
		pervisor at the			inspected on 05/04/12.		
	time of record	review, the facility					
	was purchased	by American					
	Seniors at the b	peginning of the			What measures will be put into)	
	year and the ki	tchen hood			place or what systemic change	es	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 23 of 29

DEFICIENCIES	EFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	(X3) DATE SURVEY		
ORRECTION	IDENTIFICATION NUMBER:	A BUII	DING	01	COMPLETED		
	155200				04/30/2012		
IDED OD CUIDNI IED				ADDRESS, CITY, STATE, ZIP CODE			
IDER OR SUPPLIER			1564 S	UNIVERSITY BLVD			
NURSING CEI	NTER		UPLAN	D, IN 46989			
			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
`				CROSS-REFERENCED TO THE APPROPRIA			
			TAG	·	DATE		
-	have been						
rgotten.				demoient practice acce not rec	ui.		
terview, the factorial stems was proters. NFPA 90 antilation Control of Contr	acility failed to ood extinguishing ovided with baffle 6, the Standard for strol and Fire ommercial Cooking ction 3.1 states Il not be used. This ce could affect any dining room and			will be responsible to ensure a inspections are completed as required. All required inspections who be kept by the Maintenance Director in an inspections bind. How the corrective action(s) who be monitored to ensure the deficient practice will not recur i.e. what quality assurance	vill ler. vill		
sed on obser schen hood staintenance Su 1/30/12 at 2: ters were in userview with the pervisor at the	vation of the ystem with the upervisor on 55 p.m., mesh use. Based on an the Maintenance ne time of acility was aware			be kept by the Maintenance Director in an inspections bind The Executive Director/Designee will monitor	the ly		
o The Table of State	DER OR SUPPLIER SUMMARY ST (EACH DEFICIENT REGULATORY OR Pection may gotten. -19(b) Based on obserview, the firstems was press. NFPA 90 ntilation Constection of Corrections, Security of the constant of	DER OR SUPPLIER NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) pection may have been gotten. -19(b) Based on observation and erview, the facility failed to sure 1 of 1 hood extinguishing stems was provided with baffle ers. NFPA 96, the Standard for intilation Control and Fire otection of Commercial Cooking erations, Section 3.1 states esh filter shall not be used. This ficient practice could affect any sident in the dining room and chen staff in the event of an ergency. ding include: sed on observation of the chen hood system with the intenance Supervisor on (30/12 at 2:55 p.m., mesh ers were in use. Based on an erview with the Maintenance previsor at the time of erview, the facility was aware ere were mesh filters in the od system.	DERTIFICATION NUMBER: 155200 DER OR SUPPLIER NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pection may have been gotten. -19(b) Based on observation and erview, the facility failed to sure 1 of 1 hood extinguishing stems was provided with baffle ers. NFPA 96, the Standard for intilation Control and Fire otection of Commercial Cooking erations, Section 3.1 states is filter shall not be used. This ficient practice could affect any ident in the dining room and othen staff in the event of an intergency. ding include: sed on observation of the chen hood system with the intenance Supervisor on /30/12 at 2:55 p.m., mesh ers were in use. Based on an erview with the Maintenance pervisor at the time of erview, the facility was aware are were mesh filters in the od system.	DER OR SUPPLIER NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pection may have been gotten. -19(b) Based on observation and erview, the facility failed to sure 1 of 1 hood extinguishing stems was provided with baffle ers. NFPA 96, the Standard for intilation Control and Fire obtection of Commercial Cooking erations, Section 3.1 states is hilter shall not be used. This ficient practice could affect any identified in the dining room and chen staff in the event of an intergency. ding include: sed on observation of the chen hood system with the intenance Supervisor on /30/12 at 2:55 p.m., mesh ers were in use. Based on an erview with the Maintenance opervisor at the time of erview, the facility was aware are were mesh filters in the ood system.	DER OR SUPPLIER DER OR SUPPLIER NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLANOF CORRECTION PREFIX TAG PROVIDERS PLANOF CORRECTION PROVIDERS PLANOF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLANOF CORRECTION PROVIDERS PLANOF CORRECTION PROVIDERS PLANOF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLANOF CORRECTION PROVIDENCE AND PROVIDED AND SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLANOF CORRECTION PROVIDENCE AND PROVIDED AND SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENCE AND PROVIDED AND SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENCE AND PROVIDED AND SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENCE AND PROVIDED PROVIDENCE AND PROVIDED AND PROVIDENCE AND PROVIDED AND SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENCE AND PROVIDED AND PROVIDENCE AND PROVIDED PROVIDENCE AND PROVIDED AND PROVIDENCE AND P		

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL		A. BUILDING B. WING	01	COMPLETED 04/30/2012			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD					
UNIVERS	SITY NURSING CEI	NTER	UPLAN	D, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
				monitored for a minimum of 12 months and documented on the CQI Inspections Monitoring To located in front of the Inspection Binder	ne pol			
				The CQI Inspections Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of months.				
				By what date the systemic changes will be completed:				
				· Systemic changes will be completed by 05/30/12.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 25 of 29

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200		LDING G	ONSTRUCTION 01	(X3) DATE : COMPL 04/30/	ETED
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989					
(X4) ID PREFIX TAG K0144	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=F	Generators are in exercised under month in accorda 3.4.4.1. 1. Based on obtinterview, the frensure 1 of 1 egenerators was alarm annunciar readily observed personnel at a station such as NFPA 99, Healt 3–4.1.1.15 requanunciator, st powered, shall operate outside room in a locat observed by opat a regular wo annunciator shoon ditions of the auxiliary power (a) Individual viindicate: 1. When the emauxiliary power operating to sure 2. When the bar malfunctioning (b) Individual viindividual viindi	acility failed to mergency provided with an tor in a location d by operating regular work a nurses' station. h Care Facilities, uires a remote orage battery be provided to e of the generating ion readily rerating personnel rk station. The all indicate alarm ne emergency or r source as follows: sual signals shall regency or r source is pply power to load. ttery charger is	K01	144	K 144 Generator Inspections What corrective action(s) will accomplished for those reside found to have been affected be the deficient practice: 1) A new emergency generator, remote annunciator with audible and visual alarms and battery charger is being installed at the facility. The completion date for this projector/20/12. We are requesting temporary waiver. 2) Generator load tests be performed on a monthly bast as required. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. 1) A new emergency generator, remote annunciator with audible and visual alarms and battery charger is being installed at the facility. The completion date for this projector/15/12. 2) Generator load tests	nts y r t is a will sis	07/20/2012

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED	
155200		155200	B. WIN			04/30/2012	
A VALVE OF PROVIDED OF SAME AND				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1564 S	UNIVERSITY BLVD		
	SITY NURSING CE	NTER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	,	DATE	
	an engine-gen				be performed on a monthly ba as required.	SIS	
	condition shall				as required.		
	1. Low lubricat	ing oil pressure.			What measures will be put into		
	2. Low water temperature.				place or what systemic change		
	3. Excessive wa	ater temperature.			will be made to ensure that the	l l	
	4. Low fuel – w	hen the main fuel			deficient practice does not rec	ur:	
	storage tank contains less than a				· 1) A new emergency		
	3-hour operati				generator, remote annunciator		
	5. Overcrank (f				with audible and visual alarms		
		anca to starty.			and battery charger is being		
	6. Overspeed. Where a regular work station will be unattended periodically, an				installed at the facility. The	4:-	
					completion date for this projec 07/20/12. We are requesting a		
					temporary waiver.	7	
		sual derangement			· To date the supplier has		
		riately labeled, shall			poured the cement slab and		
	be established	at a continuously			installed the annunciator pane	l.	
	monitored location. This derangement signal shall activate				The panel is being installed		
					across from the nurses' statior This location provides direct	1.	
	when any of th	e conditions in			monitoring and accessibly		
	3-4.1.1.15(a) a	and (b) occur but			capabilities by the licensed sta	iff.	
	need not displa	ay these conditions			· 2) The Maintenance		
	individually. T				Director/Designee will be		
	<u> </u>	affect all occupants.			responsible to ensure all inspections are completed as		
	practice could	arrect air occupants.			required.		
	Findings includ	de:			The Executive Director		
	Findings includ				inserviced the Maintenance		
	l				Director on the emergency		
	Based on an ob				generator required load tests,	d	
	Maintenance Si	•			documenting the load tests an maintaining those load tests for		
	04/30/12 at 1:	:10 p.m., the			record review. All required		
	emergency generator remote annunciator panel only had alarm				inspections will be kept by the		
					Maintenance Director in an		
	indicator lights	for high engine			inspections binder.		
	temperature, lo	ow oil and			How the corrective action(s) w	ill	
	overcrank. Thi				be monitored to ensure the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155200	B. WIN	G		04/30/2012
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	acknowledged Supervisor at the observation. 3–1.19(b) 2. Based on resinterview, the final maintain a commercer of month testing for 3 of months. Chapter of the generated emergency election accordance of the generated in accordance of the standard for Error S	cord review and acility failed to aplete written hly generator load the last 12 ter 3-4.4.1.1 of tes monthly testing or serving the ctrical system to be with NFPA 110, the mergency and as Systems, chapter or 6-4.2 of NFPA tenerator sets in the last 12 service to be ter operating ot less than 30 ters in greater, at for a minimum of thapter 3-5.4.2 of tes a written record performance, od, and repairs for o be regularly		TAG	deficient practice will not recur i.e. what quality assurance program will be put into place: The Maintenance Director/Designee will be responsible to ensure all inspections are completed as required. All required inspections will be heep by the Maintenance Director in an Inspections Bind. The Executive Director/Designee will monitor Inspections Binder on a month basis to ensure the required inspections have been completed. The Inspection Binder wi monitored for a minimum of 12 months and documented on th CQI Inspections Monitoring To located in front of the Inspection Binder The CQI Inspections Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of months. By what date the systemic changes will be completed: Systemic changes will be completed by 07/20/12.	vill der. the ally Il be 2 ne pool on ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W21**

Facility ID: 000107

If continuation sheet

Page 28 of 29

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155200	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMP 04/30	(X3) DATE SURVEY COMPLETED 04/30/2012		
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	jurisdiction. This deficient practice could affect all occupants.						
	Findings include:						
	Based on record review of the generator "Weekly Exercise/Monthly Load Test Log" with the Maintenance Supervisor on 04/30/12 at 12:05 p.m., there was no documentation of a generator load test for the months of October through December 2011. This was acknowledged by the Maintenance Supervisor at the time of record review. 3.1–19(b)						

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Event ID: **765W21**

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If continuation sheet

Page 29 of 29